Editorial

Stroke Awareness Month

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May is Stroke Awareness Month. Stroke is now the nation's third leading cause of death. 28% of stroke patients are under 65! The good news is that almost four million Americans have survived strokes.

A very interesting report on Stroke Prevention Medication appeared in *Stroke*[1] by Larry Goldstein, MD. (no relation), David Matchar, MD et al.

The Stroke Patient Outcomes Research Team (SPORT) based at Duke University analyzed the responses of 1,006 physicians who participated in the national study.

While 85% of all responding physicians always or often prescribed aspirin or other platelet anti-aggregants, not all prescribed them at the same rate. As measured by the odds ratio, neurologists or internists were about two-thirds more likely than surgeons to prescribe these medications.

Pertaining to anticoagulants, non-internist primary care physicians prescribed five times more, internists 3.5 times more, and neurologists two times more than surgeons.

The researchers suggest that some of the variations in practice may be attributed to physicians' uncertainty. Clinical trial data are rapidly becoming available to help guide the specific type of patients at elevated risk of stroke.

1. U.S. National Survey of Physician Practices for Secondary and Tertiary Prevention of Ischemic Stroke. *Stroke* 27(9)1473-1478, 1996.

Editors Note:

Mahalo to the Ethics Awareness Committee of the American Academy of Dermatology for providing the Patient-Physician Convenant on page 129. The Patient-Physician Convenant reflects the professional attitude that we all have in regard to our patients today and sends a very positive message to our patients. Please feel free to frame this copy for your office.

Letter to the Editor

Physician-assisted Dying: The Coming Debate

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As many of us eye the imminent Supreme Court decision on physician assistance in dying (PAD), there is reason to be apprehensive that Hawaii, like many other states, will too soon have to consider the practice-standards, laws and regulations that should govern it. Right now, at best, there is no clear legal standard in this state, no shared understanding of what PAD might look like. In some ways, we are very much like Kevorkian's Michigan. The coming Supreme Court opinion will likely settle whether states can issue blanket prohibitions on physician-assisted dying (as New York and Washington—but not Hawaii—have done) or whether there is a Constitutionally-protected liberty interest that prevents this.

In either event, I expect we will have legislative work to do. For if New York and Washington win in the Supreme Court, we are going to have to argue the question of legalization. It would be an advantage if the candidate laws and regulations were as intelligently drafted as possible. But if New York and Washington lose, the issue of legality will be settled and it will only remain to draft our laws and regulations. Regardless of the court's decision, Hawaii would benefit from an improved understanding of the regulative and professional options that are open to us. The most effective way of realizing that goal would be a public conference focusing on our alternatives.

Let me list a few of the pertinent questions that such a conference might cover.

1. What medical conditions would a patient have to meet in order to be eligible under the regulations for PAD? Three of the most discussed criteria involve terminal illness, unmitigable pain and unrelievable suffering (a much broader concept than pain).

2. What cognitive capacities must patients have in order to be eligible for such assistance? Two of the most discussed options involve decisionally-capacitated patients who have repeatedly made such requests and formerly capacitated patients who have prepared an appropriate advance directive.

3. What procedures should be in place to ensure that the standard set in the answers to #1 and #2 are met? Currently discussed options involve the establishment of specialized "palliative care" review committees and independent physicians to provide second opinions about decisional capacity, the underlying medical disorders and treatability. Waiting periods have been discussed in connection with some types of case, as has the routine use of counseling.

4. What assistance can patients ask for? Two of the most discussed options involve the writ-